DEPARTMENT OF SOCIAL & HEALTH SERVICES
HEALTH & RECOVERY SERVICES ADMINISTRATION
July 28, 2006

SeaTac Marriott
3201 S. 176th Street
Seattle, WA 98188

Members Attending

Janet Varon
Katherine Harris-Wolburg for Maria Nardella
Chris Jankowski, OD
Claudia St. Clair
Jerry Yorioka, MD
David Gallaher
Kyle Yasudad, MD
Blanche Jones
Eleanor Owen
Barbara Malich
Mark Secord

Members Not Attending

Kathy Carson
Allena Barnes
David Houten, DDS
Elyse Chayet

HRSA Staff

Doug Porter
Debbie Meyer
Jim Stevenson
Steven Wish
MaryAnne Lindeblad
Roger Gantz
Jeff Thompson, MD

Guests

Mary Selecky
Huy Nguyen
Bob Perna
Ken Stark

Approval of the Minutes

Kyle Yasuda had a change to the minutes. With that change, the minutes for the May 26, 2006 meeting were approved.

The agenda for the July 28 meeting was approved.

Call for Nominations for the Chair & Executive Committee Members

Janet stated that it was time to start thinking about selecting a new chair for the committee. She asked that people start thinking about who from the committee they would like to nominate.

Claudia St. Clair nominated Mary Selecky as a candidate for the chair of the committee. Additional nominations are welcome and should be sent to Janet Varon.

Mental Health Transformation Grant

Ken Stark handed out a document that was prepared for a MHTG meeting in May.

The transformation grant arose from discussions by the President's New Freedom Commission. It came about because there was concern about the mental health system being fragmented.

There are six goals:

- Americans understand that mental health is essential to overall health
- Mental health care is consumer and family driven
- Disparities in mental health services are eliminated
- Early mental health screening, assessment and referral to services are common practice
- Excellent mental health care is delivered and research is accelerated
- Technology is used to access mental health care and information

Washington was one of seven states awarded one of the five-year grants (totaling about $2.7 million each year). The state was urged to submit an application for a grant by the joint legislative-executive task force reviewing mental health service delivery last year..

One of the requirements of this grant is to have an advisory committee. There are 32 people on the committee and this group is overseeing the project.

The Committee wanted to add two goals – housing and employment.

Transformation is a recovery-oriented model, consumer/family driven and outcome-focused.

Each state will be defining how far they go in being consumer/family driven and how outcome-focused they are.

The outcome stuff goes along with the GMAP process that agencies are focused on right now. We will be looking at the data systems to see if they can link so that we can track outcomes.

Right now Ken's workgroup is putting together a comprehensive mental health plan. The first draft is due out in August. There will be a two week review period, and the revised plan will be shared with the MHTG advisory committee at a meeting in late August. It was to be submitted to the Governor's Office on September 1. In final form, it is due to the federal government on September 30.

The state workgroup formed seven subcommittees and asked each of them to come up with two or three recommendations about improving services or service delivery in their special area of concern.

Workgroup members and Transformation Grant staff also met with a number of groups, asking for their input. Should we have universal screening? Universal outcome measures? Ken said there were a number of questions.

What about prevention and early intervention? Ken said a reality is that we don't seem to have enough money for these services. Instead, we spend most of our money on the most severe cases.

Ken said that the community process produced good information but not necessarily in-depth information. More work is needed. Bob Perna asked: Can you provide data about how many clients need prevention services as opposed to crisis care? Ken stated that he didn't think this data was available because the systems aren't collecting it. At some point in time we'll have to make decisions about where our priorities are. But he said he thought it would be a mistake to model the program around Medicaid because it's a medical model.

The five-year process and the $14 million sound like an amazing windfall, but Ken said there are problems. How do we anticipate what the deteriorating system will look like in five years? The plan must address this "defragmentation."

The real question, he said, is: Are we ever going to come to a point where we CAN refocus on mental health not mental illness.

Doug said it would be wrong to assume that the state is putting mental health issues on hold during the five-year planning process. He noted that improvements are still in the works and that some are addressed in the current budget proposals.

Jerry Yorioka noted that he attended the Blue Ribbon Commission meeting yesterday and spent a large portion of Monday trying to find a placement for his patient. Dr. Yorioka believes there are instances that patients are getting mental health misdiagnosis. Ken stated that there were a number of patients and family members who felt that very same way.

Ken said he realizes after a year's worth of research that the communications problems are enormous. A number of groups don't know there are other groups out there talking about the very same things. We need to network them together.

Citizenship verification

Steven Wish handed out several documents related to the documentation of citizenship.

The federal Deficit Reduction Act of 2005 included new requirements for documentation and verification of citizenship for Medicaid clients. This new law went into effect July 1, 2006.

CMS issued a lengthy letter that gave states direction on how to implement the program. We received 93 pages of rules just a few days before July 1.

One of the most important changes in that letter was to exempt dual-eligible individuals (clients of both Medicaid and Medicare) from this program. Previously, CMS had hinted they would be included.

Washington was one of the first states in the country to implement procedures to start establishing citizenship documentation. Beginning on July 3, new applicants on Medicaid were

issued declaration forms to provide information about where their citizenship documentation might be on file. In the future, each person applying will need to fill out this form, which really starts the process of determining eligibility. A special unit based in Olympia will use the information on the form to track down birth certificates and other documents that may be available through the Department of Health, county governments inside and outside Washington State, etc. In some cases Washington may be able to use information in its own Automated Client Eligibility System (ACES) to establish U.S. birth records for children.

No existing Medicaid client will be kicked off the program without a reasonable opportunity to provide similar documentation or tell the state where it can be found. Starting in September, as we do eligibility reviews we'll be requesting the same kind of documentation from current clients as they undergo their regular six-month or annual reviews of eligibility.

Where the state will be out in front is in its close working relationship with the Department of Health, which maintains statewide birth records. Thanks to cooperation and close links between the two agencies, Washington will be able to do a fast, electronic data match for a high percentage of Medicaid clients.

Title XIX members suggested that HRSA draft a fact sheet for clients that will provide them with this kind of information.

Despite the good news, HRSA does expect the additional citizenship-documentation requirements will be costly. Federal officials estimated that the new requirement would only take an extra five minutes per case. DSHS is estimating much more of a workload.

Federal officials also predicted that the number of non-citizens removed from the rolls around the country would essentially cover any extra costs. However, national studies have not detected significant numbers of non-citizens in Medicaid. Washington State sampled our caseload and out of 400 randomly selected clients did not find any noncitizens posing as citizens.

Budget

The Budget process will be finalized in September. There is still a lot of work going on. Preliminary information has been given to the Secretary.

Doug stated that the following areas are on the table to request funding.

- Part D co-payments for dual eligibles.
- Citizenship verification – will probably have to absorb the current costs
- Move into the world of electronic medical records – will be asking for dollars for a study
- Chronic care management
- Foster care integration – to provide better medical and mental health services
- Health disparities
- Children's Health Program is currently as 100% FPL. We will be asking to children between 100-150% FPL to cover these kids
- Alien Emergency Medical Program

- Establish MH services for GAU clients
- Increase children's dental program
- Family Opportunity Program – families with disabled children could buy-in to medical coverage up to 300% FPL

Janet noted that the list did not include restoration of the adult dental cuts mandated by the Legislature several years ago. HRSA staff said a discussion with the Dental Association about the cuts showed that dentists felt the state should use any increased budgeting to increase the rates of the existing services that are covered under the adult dental program.

Health Care Disparities Sub-group Report

MaryAnne thanked the committee members who participated in this sub-group. She said the Decision Package is still moving – we are looking at a pilot to have health navigators.

The workgroup will continue to have conference calls about once a month. MaryAnne said the group also needs to talk about what will happen if the decision package isn't funded. One option would be to look at other funding sources. But she said she remains optimistic that the Dcision Pckage will go forward and that the Lgislature will approve the funding.

One success was to arrange a workshop with a group called the First Friday group. There were eight presenters who presented their projects. We are compiling the information shared and will get that information out to the advisory committee members.

Janet drafted a health navigator job description. She said it was not prescriptive but just a good place to start.

Eleanor felt the workshop was outstanding. She thought it would be a great idea to have a conference so that more presenters could share more things being done in communities.

Dr. Yasuda applauded the decision package and said the in-person navigator was very important. He believes that it costs us more in the health-care delivery system if we have to use a telephonic system because providers end up needing more visits to get a clear picture.

Health Disparities Presentation – Dr. Jim Krieger

Dr. Krieger works for the Seattle-King County Public Health Department.

What is a community health worker and what do they do? They have to be from the community that they work in. They should have personal experience with what they're talking about. This way they can get the trust and respect from the client.

Community health workers can be trained to work in various areas – ranging from outreach to being client advocates. They can reconnect the disconnects. In some ways, they are very similar to the "navigator"-type functions being considered by the disparities workgroup.

Dr. Kreiger shared information on how Seattle-King County Public Health has done in the asthma and diabetes area.

Community health workers make 5-7 visits to low-income children with asthma. The CHW assess home environment and develop environmental action plan to reduce exposure to moisture, tobacco smoke, mites, mold, pets & roaches.

Community health worker home visits:

- Provide education and encourage behaviors
- Link clients to clinical care
- Advocate and promote communication
- Provide social support
- Offer advocacy/referral to housing, food, furniture, jobs, etc.
- Provide trigger to control resources

Barriers for implementing CHW programs

- Lack of stable funding
- Need for standardized certification
- Need for greater career opportunities
- Need for trained workforce

Eleanor said the need for this kind of intervention is clear. It's an old, old idea that needs to be brought back.

Claudia stated that the health-care use sub-group is following along the same lines as the health disparities sub-group. Developing this kind of intermediary is one of their recommendations, too.

Eleanor made a motion to accept the recommendations made at the end of the presentation. Dr. Yorioka seconded the motion. The recommendations were:

- Fund CHW programs for Medicaid enrollees
- Support establishment of certification process
- Collaborate with community colleges to offer CHW training and programs

Barb's comment is that she felt it wasn't as simple as just adopting the three recommendations,. however. There could be a variety of needs, she noted, and there is a wide network of community health workers.

Doug and Dr. Thompson meet a couple of times a year with WSMA's interspeciality committee, and Bob said it would be a good idea to invite Dr. Krieger to make his presentation for that group of providers.

The motion was amended to expand the second recommendation so that it includes: "exploring the advantages and disadvantages of the certification process and looking at other models already in existence".

Health Care Use Sub-Group Report

Doug suggested that this group meet with outreach workers and see what's being done so you don't have to reinvent the wheel. A meeting was scheduled for July 18 with the outreach workers.

The sub-group said its discussion focused on four key points:

- Increased funding to the current outreach efforts that are already in place
- Simplification of enrollment and communication
- Provider outreach
- Development of DSHS/CSO outreach workers

Numbers 1 & 2 are the top items.

Steven noted that HRSA is working on a proposal to use some of the unspent CHIP dollars. There is only limited funding available. - $1.9 million in federal dollars. Washington State would have to establish guidelines for spending the money, since under Title XXI funds can only be used for eligibility and outreach.

In the past the eligibility and outreach worker has been located at the CSO. These workers deal with assisting a person to become eligible for food stamps, medical coverage, Employment Security, etc. Outreach workers connect to the environmental issues.

Janet asked Claudia what the next steps are? Claudia said she was not sure, but Barb said one option would be to bring some of the presenters to a future Title XIX Advisory Committee.

Steven suggested it might be a good time for the two sub-groups to have a meeting together.

Nominations Reminder

Janet reminded people about submitting nominations for a new chair and new executive committee members. The nominations are to be sent to Janet by September 8.